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Medicare Tomorrow: Future Savings for Beneficiaries

Estimates of the Impact of Medicare Prescription Drug Coverage on Low-Income Beneficiaries—State-Level Estimates

Prepared for

The Alliance to Improve Medicare &

Medicare Today

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The Alliance to Improve Medicare (AIM) and the Medicare Today partnership requested PricewaterhouseCoopers LLP to estimate the effects of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 on low-income beneficiaries by state.

Impact of the Medicare Prescription Drug Coverage on Medicare Beneficiaries: U.S. National Summary

On December 8, 2003, the President signed the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), which added a prescription drug benefit as part of the Medicare program. Under the new law, Medicare will offer complete prescription drug coverage to qualifying low-income beneficiaries with minimal cost sharing and no premiums.

The MMA significantly improves prescription drug coverage for low-income (non-federal coverage) beneficiaries.[1] Specifically, PricewaterhouseCoopers found:

- Participation in the new drug benefit will be about 96 percent (about 8 million) of low-income beneficiaries compared to 52 percent of these individuals not receiving any drug coverage pre-MMA.
- Out-of-pocket spending by low-income Medicare beneficiaries that are eligible and participate will fall from about $1,657 pre-MMA to an estimated $180 under the MMA. For those beneficiaries who are uninsured and low-income, the difference between out-of-pocket spending pre- and post-MMA is even greater—$1,905 pre-MMA versus $130 post-MMA.
- The low-income population that is eligible and participates will receive a federal subsidy, on average, of about $2,048.

How to Read the State Tables

The left-hand side of the each state table contains information on the low-income Medicare population including those with Medicaid as well as those who are not eligible for Medicaid. The estimates were based on the March 2004 Current Population Survey. For example, 33 percent of low-income Medicare beneficiaries in Alabama are male and 67 percent female.

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[1] Federal is defined as Medicare beneficiaries with prescription drug coverage from CHAMPUS, Department of Defense, VA, Medicaid and other government sources.

Low-income includes individuals at or below 150 percent of the federal poverty level.

The middle section of the state table contains information on the number of Medicare beneficiaries who are not enrolled in Medicaid and other federal programs such as CHAMPUS, Department of Defense, and VA. The upper panel includes both low-income and high income Medicare beneficiaries while the lower panel includes only those low-income Medicare beneficiaries who are eligible for the low-income benefit. For example, Alabama has 532,446 Medicare beneficiaries who are not covered by Medicaid or other federal programs and 133,671 of them are eligible for the low-income benefit. In the absence of the MMA, about 55 percent of all Alabama Medicare beneficiaries have drug coverage compared to only 37 percent of the low-income group.

The right-hand side of each state table contains information on spending, out-of-pocket, and federal subsidies.[2] The top panel shows averages across all Medicare beneficiaries (except for those enrolled in federal programs) and the lower panel shows comparable estimates for those who are low-income. For example, in the top panel, we estimate that average spending in Alabama is $3,177 per beneficiary pre-MMA and $3,067 post-MMA. The lower spending post-MMA reflects a combination of higher drug utilization offset by lower prices.[3] Estimates of cost sharing assume that all Medicare beneficiaries who are eligible for the low-income subsidies receive them. For example, in Alabama, low-income beneficiaries are estimated to have out-of-pocket spending of $1,845 in 2006 in the absence of the MMA but average out-of-pocket of only $200 under the new Medicare Part D program. Federal subsidies per low-income Medicare beneficiary, assuming that all eligibles participate, would be $2,282.[4]

The lower part of each state table contains a chart that compares pre-MMA and post-MMA out-of-pocket expenses on prescription drugs. For example, in Alabama, the average Medicare beneficiary is estimated to have cost sharing of $1,727 in the absence of the MMA and $961 under the MMA, a reduction of more than $700 per Medicare beneficiary. The chart shows that the low-income uninsured beneficiary is estimated to have cost sharing of $2,122 in

[2] Spending refers to the total costs of prescription drugs for the beneficiary regardless of whether the insurer or beneficiary pays for the drugs. Out-of-pocket spending refers to what the beneficiary spends; this spending does not include the cost of premiums many beneficiaries pay under current insurance plans nor does it include the premiums that most beneficiaries pay under Medicare Part D. Federal subsidy refers to the portion of total costs paid by the federal government under Medicare Part D.

[3] CBO estimates that average drug prices are lower post-MMA because more Medicare beneficiaries will be under managed pharmacy benefits in which discounts are negotiated with both drug companies and retail pharmacy networks.

[4] Low-income Medicare beneficiaries who have coverage from former employers who do continue to provide prescription drug coverage are assumed to continue to pay the cost sharing associated with those employer plans.

the absence of the MMA and $145 under the MMA, a reduction of more than $1,900 per Medicare beneficiary.[5]

[5] These numbers reflect not only the level of drug coverage prior to the MMA but also other differences between the groups that are reflected in lower spending per capita pre- and post-MMA.

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Impact of Medicare Prescription Drug Benefit on Non-Federal Beneficiaries, CY 2006 [1]
ALABAMA

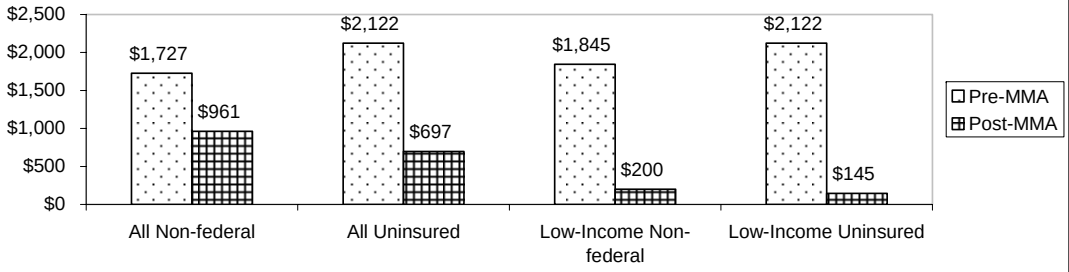
Low-Income Demographics [2]	
Characteristic	**<=150% Federal Poverty Level**
Gender	
Male	33%
Female	67%
Marital Status	
Married	16%
Widowed/Divorced/Separated	58%
Never Married	26%
Age	
< 65	38%
65+	62%
Race	
White	55%
Black	45%
American Indian/Alaskan	*
Asian/Pacific Islander	*
Hispanic (of any race)	*
Prescription Drug Coverage	
Private	20%
Public	45%
Self-Pay	34%

* Less than 4 percent.

Prescription Drug Coverage Pre- and Post-MMA		
Types of Beneficiaries	**Pre-MMA**	**Post-MMA**
All Medicare	532,446	
With Rx Drug Coverage	291,814	513,538
Without Rx Drug Coverage	240,632	18,908
Percent with Coverage	55%	96%
Low-Income Beneficiaries	133,671	
With Rx Drug Coverage	49,887	127,087
Without Rx Drug Coverage	83,784	6,584
Percent with Coverage	37%	95%

Impact on Beneficiary		
Average Per Capita	**Pre-MMA**	**Post-MMA**
All Medicare		
Out-of-Pocket [3]	$1,727	$961
Spending [4]	$3,177	$3,067
Federal Subsidy [5]	N/A	$1,315
Low-Income Beneficiaries		
Out-of-Pocket [3]	$1,845	$200
Spending [4]	$2,942	$2,860
Federal Subsidy [5]	N/A	$2,282

Medicare Prescription Drug Coverage will Significantly Lower Out-of-Pocket Spending for Medicare Beneficiaries



Source: PricewaterhouseCoopers' tabulations, August 2005. Gender, marital status, age, and race were tabulated from the US Census March 2004 Current Population Survey.
Notes:

1. Federal is defined as Medicare beneficiaries with prescription drug coverage from CHAMPUS / DoD, VA, Medicaid and other government sources.
2. Low-income includes individuals at or below 150 percent of the federal poverty level.
3. Out-of-pocket spending does not include premium costs.
4. Spending is the total costs of prescription drugs for the beneficiary regardless of whether the insurer or beneficiary pays for the drugs.
5. Includes beneficiaries eligible and participating in the low income subsidy.

The following is a description of the methodology we used to provide prescription drug coverage and demographics for each state, focusing on the low-income population. The low-income population is defined as individuals who have income less than or equal to 150 percent of the Federal Poverty Level.

Data Sources for Medicare Beneficiaries by Income, Insurance Coverage, and State of Residence in 2006

We based our state estimates of current prescription drug coverage on the March 2004 Current Population Survey (CPS) that reports on supplemental health insurance coverage by state and by poverty level for the year 2003.[6] We then converted supplemental health insurance coverage to prescription drug coverage by multiplying each type of supplemental insurance by the average percent of plans that have prescription drug coverage. These percentages were based on the Medicare Current Beneficiary Survey (MCBS).[7]

Number of Medicare Beneficiaries by State

The total Medicare population in Part B by state is based on enrollment reported by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid (CMS).[8] The CMS-reported number of Medicare enrollees by state was used to adjust the raw data from the CPS, as described below. For example, if the CPS showed that a state had 100,000 Medicare beneficiaries while CMS enrollment was 105,000, then each and every count in the CPS for that state would be increased by five percent. In this same example, if the number of low-income, uninsured Medicare beneficiaries in the CPS was estimated to be 10,000, that estimate would be increased to 10,500, a five-percent increase.

Demographics of Low-Income Medicare Beneficiaries

Demographics of the Medicare population were also based on the March 2004 CPS. This survey provides state-level information on a variety of demographic and economic characteristics by type of supplemental coverage. Although the CPS has a reasonable sample of Medicare beneficiaries in every state, estimates for some subcategories are subject to significant sampling error. For example, although there are 235 observations from Alaska, 87 of which are beneficiaries whose reported income is less than 150 percent of poverty, no

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[6] U.S. Census Bureau (2004). Current Population Survey. March 2004.

[7] Adapted from Poisal, JA and Murray, L (2001). "Growing Differences Between Medicare Beneficiaries With and Without Drug Coverage." Health Affairs. 20(2): 74-85. March/April 2001.

[8] Centers for Medicare & Medicaid Services (2003). "Medicare Enrollment - All Beneficiaries as of July 2003." website: http://www.cms.hhs.gov/statistics/enrollment/st03all.asp. Accessed: July 25, 2003.

respondents were Hispanic and only a few were African-Americans. For that reason, the cells of less than four percent are reported as asterisks ("*").

Estimates of Prescription Drug Coverage by State

Prescription drug coverage is estimated by the type of supplemental insurance held by Medicare beneficiaries in the CPS sample. Prescription drug coverage in the absence of Medicare Part D (pre-MMA) was estimated as follows:

- Medicare beneficiaries with no supplemental coverage were assumed to have no drug coverage.
- Other Medicare beneficiaries who had supplemental coverage were assigned drug coverage based on data from the MCBS. For example, most Medicare beneficiaries with Medicare Advantage coverage have prescription drug coverage but the majority of beneficiaries with Medigap coverage do not. Specifically, we assumed that 90 percent of Medicare Advantage (MA) enrollees but only 35 percent of Medigap purchasers had prescription drug coverage.

Prescription drug coverage under Medicare Part D (post-MMA) was estimated as follows:

- Medicare beneficiaries who are enrolled in Medicare Part B and who do not have supplemental insurance coverage from former employers or the federal government, such as CHAMPUS, Department of Defense, and Veterans Administration, are assumed to enroll in the new Medicare Part D.
- Enrollees who are covered by federal government plans, such as CHAMPUS, Department of Defense, and Veterans Administration, are assumed to be excluded from the new Medicare Part D and continue to receive their coverage from those plans. (These Medicare beneficiaries are excluded from most of the state estimates reported by PricewaterhouseCoopers.)
- Medicare beneficiaries with coverage from former employers are split into three groups—those whose employers continue to offer coverage and receive a 28 percent subsidy from the federal government, those whose employers drop coverage altogether, and those whose employers encourage them to enroll in a Medicare Part D private prescription drug plan and provide supplementation. The Congressional Budget Office (CBO) estimated that only about 23 percent of employers would drop current coverage and provide no supplementation to the Medicare Part D plan.

- Low-income Medicare beneficiaries are eligible for additional assistance in the form of low-income subsidies that reduce cost sharing and premiums. We estimate that about 87 percent of low-income Medicare beneficiaries also meet asset tests and are eligible for the low-income subsidies.

Prescription Drug Spending and Cost Sharing by Medicare Beneficiaries

Estimates of prescription drug spending and cost sharing, in the absence of Medicare Part D (pre-MMA), were based on the MCBS as well as CBO's estimate of average drug spending in 2006.[9] In order to adjust the amounts by state, PricewaterhouseCoopers applied the state's ratio to the national total for prescription drug expenditures per capita for this particular population (we calculated the ratio based on CMS Final Drug Plan Bidder Data Sets).[10]

Prescription drug spending, cost sharing, and premiums under the new Medicare Part D coverage were based on the following assumptions:

- The standard Medicare Part D benefit pays for roughly 53 percent of prescription drug costs.
- The beneficiary also pays a premium equal to 25.5 percent of the average cost for the Medicare Part D prescription drug plan.
- Medicare beneficiaries who have better coverage under Medicare Part D than under their pre-MMA plan will use more drugs and our estimate was based on an elasticity of minus 0.3, which is consistent with CBO's assumptions about additional prescription drug use under Medicare Part D.
- Prescription drug prices, net of discounts, are lower under the MMA and this is reflected by the average spending per capita declining under the MMA despite higher drug use by some Medicare beneficiaries.

The estimates also reflect special treatment for low-income Medicare beneficiaries. Medicare low-income beneficiaries, based on income and assets, may qualify for either Subsidy A or Subsidy B. PricewaterhouseCoopers based its estimate of out-of-pocket spending, by low-

[9] Congressional Budget Office (2004). "A Detailed Description of CBO's Cost Estimate for the Medicare Prescription Drug Benefit." U.S. Government Printing Office. July 2004.

[10] Published as part of the "Drug Plan Bidder Data Sets (Final)." This file was a subset of the Medicare 5% file with drug coverage imputed from the Medicare Current Beneficiary Survey. It is no longer available on CMS website.

income spending post-MMA, on a "blended copayment" (40 percent generic scripts, 60 percent brand) of $3.80 under Subsidy A, and copayments based on a $50 deductible and 15 percent coinsurance for those under Subsidy B. The average subsidy across both groups was based on the assumption that those under Subsidy B are 24 percent of total non-dual low-income eligibles. In order to adjust the amounts by state, PricewaterhouseCoopers applied the same ratio from CMS that was used to adjust the pre-MMA out-of-pocket spending.

PricewaterhouseCoopers reduced out-of-pocket spending estimates for low-income Medicare beneficiaries by the estimated low-income subsidies. The actual out-of-pocket spending would be higher to the extent that low-income beneficiaries do not sign-up for the low-income subsidies. CBO assumed that only about 40 percent of Medicare beneficiaries, who do not have Medicaid, would participate in the low-income subsidy program. CMS assumed that a majority would do so.[11]

Adjustments and Improvements to Raw Data

The raw data from CPS and other sources were adjusted to account for a number of weaknesses in the raw data:

1. The state Medicaid estimates from the CPS were replaced by the actual state Medicaid full-dual eligibles as reported by the states.[12]

2. CPS has information on private individual coverage, which includes both Medigap and Medicare Advantage (Medicare risk plans such as HMOs). PricewaterhouseCoopers separated this coverage into Medigap and Medicare Advantage, based on official CMS estimates of Medicare Advantage enrollment by state.[13]

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[11] Although our estimates are based on 100 percent participation, the difference in out-of-pocket spending in the case where only 40 percent participate and the case where 70 percent and 100 percent do so is not large if the nonparticipants are those who have low prescription drug spending. For example, if the 60 percent of Medicare beneficiaries with the lowest spending do not participate in the low-income subsidy, they account for only 3.5 percent of spending and a large percentage of subsidies would continue to be paid out despite the low participation rate. CBO (2004). "Letter to Honorable Jim Nussle Comparing CBO and Administration Estimates of the Effect of H.R. 1 on Direct Spending." U.S. Government Printing Office. February 2004.

[12] Kaiser Family Foundation, Statehealthfacts.org (2003). "Dual Eligibles Enrollment, 2003." website: http://statehealthfacts.org/cgi-bin/healthfacts.cgi?action=compare&category=Medicare&subcategory=Dual+Eligibles&topic=Dual+Eligibles+Enrollment&link_category=&link_subcategory=&link_topic=&viewas=&showregions=0&sortby=&printerfriendly=0&datatype=number. Accessed: July 28, 2005.

[13] CMS (2005). "Medicare Advantage Payment Rates Information." website: http://www.cms.hhs.gov/healthplans/rates/default.asp. Accessed. July 22, 2005.

3. CPS estimates are less reliable for smaller states, especially for subpopulations. Low-income Medicare beneficiaries are usually around five percent of each state's population. For smaller states, the CPS estimates of the number of low-income Medicare beneficiaries who do not have drug insurance would be subject to a high degree of uncertainty. In the case of the 15 states with the lowest number of Medicare beneficiaries, the low-income uninsured from CPS (i.e., those who do not have prescription drug coverage) was replaced by recent estimates from CMS based on a number of sources.[14]

4. The raw data, such as the March 2004 CPS, do not fully reflect 2006, the year in which Medicare beneficiaries enroll in Part D. All of the raw data have to be adjusted to reflect higher Medicare enrollment and higher prescription drug prices in 2006 as compared to 2002 and other years.

5. The sum of various components of state estimates does not usually sum to known totals (or official estimates from CBO or CMS). In most cases, the raw data were adjusted to yield sums that matched these known benchmarks.[15]

The adjustments described above produce a set of state estimates that sum to national totals consistent with the assumptions behind CBO's estimates of the federal budgetary costs of the Medicare Part D prescription drug coverage.

Conclusion

Low-income Medicare enrollees will receive significant benefits from this legislation. Eligible low-income beneficiaries will not only receive the standard benefit for either no premium or a reduced premium, they also face little cost-sharing requirements. The low-income subsidies eliminate the coverage gap and most cost-sharing above the catastrophic spending cap. The new benefit will represent a significant improvement in drug coverage for most low-income beneficiaries.

[14] Calculated from CMS "Drug Plan Bidder Data Sets (Final)."

[15] Congressional Budget Office (2004). "A Detailed Description of CBO's Cost Estimate for the Medicare Prescription Drug Benefit." U.S. Government Printing Office. July 2004.